CONFIDENTIAL HEALTH INFORMATION

Please allow our staff to photocopy your driver's license and insurance details.
All information you supply is confidential. We comply with all federal privacy standards.
Please print clearly.

Paun Family Chiropractic and Wellness, P.C.
2022 45th Street
Highland, IN 46322
Office: 219-227-4033
Fax: 708-931-0119
www.PaunWellness.com

Today's Date (MM/DD/YYYY)

Have you consulted a chiropractor before?
◯No ◯Yes When?

Patient Number (office use only)

Whom may we thank for referring you?

If so, whom?

Your Last Name | Your Social Security Number | Birth Date (MM/DD/YYYY) | Age

Your First Name | Your Middle Name (or Initial)

Gender
◯Male ◯Female

Race

Address

Marital Status ◯Married ◯Single ◯Divorced ◯Widowed ◯Separated

Ethnicity
◯Hispanic ◯Non-Hispanic

City | State/Province | ZIP/Postal Code

Preferred Language

Home Phone | Cell Phone | Spouse's Name

Email Address | Cell Phone Carrier | Child's Name and Age

Emergency Contact | Emergency Contact's Phone | Child's Name and Age

Your Occupation | Child's Name and Age

Your Employer | Work Phone

Address

May we contact you at work?
◯Yes ◯No

City | State/Province | ZIP/Postal Code

Preferred method of contact?
◯Home Phone ◯Cell Phone
◯Work Phone ◯Email

Primary Care Provider's Name

Insurance Carrier | Policy Number

Insured's Last Name | Birth Date (MM/DD/YYYY)

Who carries this policy?
◯Self ◯Spouse ◯Parent

Insured's First Name | Insured's Middle Name (or Initial)

Insured's Employer

Address

City | State/Province | ZIP/Postal Code | Employer's Phone

CONFIDENTIAL HEALTH INFORMATION

1. The symptom(s) that have prompted me to seek care today include: _____

_____

2. And are the result of (darken circle): ◯ An accident or injury
◯ Work ◯ Auto ◯ Other _____
◯ A worsening long-term problem
◯ An interest in: ◯ Wellness ◯ Other _____

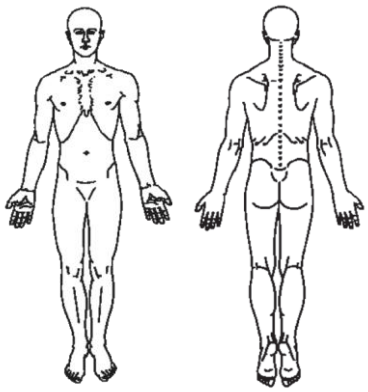
3. Onset (When did you first notice your current symptoms?)
_____

4. Intensity (How extreme are your current symptoms?)
0 ◯—◯—◯—◯—◯—◯—◯—◯—◯—◯—◯ 10
Absent Uncomfortable Agonizing

5. Duration and Timing (When did it start and how often do you feel it?)
◯ Constant ◯ Comes and goes. How Often? _____
_____

6. Quality of symptoms (What does it feel like?)
◯ Numbness
◯ Tingling
◯ Stiffness
◯ Dull
◯ Aching
◯ Cramps
◯ Nagging
◯ Sharp
◯ Burning
◯ Shooting
◯ Throbbing
◯ Stabbing
◯ Other _____

7. Location (Where does it hurt?)
Circle the area(s) on the illustration.
"0" for current condition
"X" for conditions experienced in the past



8. Radiation (Does it affect other areas of your body? To what areas does the pain radiate, shoot or travel.)
_____

9. Aggravating or relieving factors (What makes it better or worse, such as time of day, movements, certain activities, etc.)
What tends to worsen the problem? _____
What tends to lessen the problem? _____

10. Prior interventions (What have you done to relieve the symptoms?)
◯ Prescription medication ◯ Surgery ◯ Ice
◯ Over-the-counter drugs ◯ Acupuncture ◯ Heat
◯ Homeopathic remedies ◯ Chiropractic Other _____
◯ Physical therapy ◯ Massage _____

11. What else should Paun Family Chiropractic and Wellness know about your current condition? _____

_____

12. How does your current condition interfere with your:

Work or career: _____

Recreational activities: _____

Household responsibilities: _____

Personal relationships: _____

13. Review of Systems
Chiropractic care focuses on the integrity of your nervous system, which controls and regulates your entire body. Please darken the circle beside any condition that you've **Had** or currently **Have** and initial to the right.

a. Musculoskeletal

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Osteoporosis	◯	◯	Arthritis	◯	◯	Scoliosis	◯	◯	Neck pain	◯	◯	Back problems	◯	◯	Hip disorders
◯	◯	Knee injuries	◯	◯	Foot/ankle pain	◯	◯	Shoulder problems	◯	◯	Elbow/wrist pain	◯	◯	TMJ issues	◯	◯	Poor posture

NONE ◯ Initials ____

b. Neurological

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anxiety	◯	◯	Depression	◯	◯	Headache	◯	◯	Dizziness	◯	◯	Pins and needles	◯	◯	Numbness

NONE ◯ Initials ____

c. Cardiovascular

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	High blood pressure	◯	◯	Low blood pressure	◯	◯	High cholesterol	◯	◯	Poor circulation	◯	◯	Angina	◯	◯	Excessive bruising

NONE ◯ Initials ____

d. Respiratory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Asthma	◯	◯	Apnea	◯	◯	Emphysema	◯	◯	Hay fever	◯	◯	Shortness of breath	◯	◯	Pneumonia

NONE ◯ Initials ____

e. Digestive

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Anorexia/bulimia	◯	◯	Ulcer	◯	◯	Food sensitivities	◯	◯	Heartburn	◯	◯	Constipation	◯	◯	Diarrhea

NONE ◯ Initials ____

f. Sensory

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Blurred vision	◯	◯	Ringing in ears	◯	◯	Hearing loss	◯	◯	Chronic ear infection	◯	◯	Loss of smell	◯	◯	Loss of taste

NONE ◯ Initials ____

g. Skin

Had	Have		Had	Have		Had	Have		Had	Have		Had	Have		
◯	◯	Skin cancer	◯	◯	Psoriasis	◯	◯	Eczema	◯	◯	Acne	◯	◯	Hair loss	◯	◯	Rash

NONE ◯ Initials ____

Consultation Notes

Patient name _____

Patient Number (office use only) _____

Doctor's Initials _____

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(Continued from previous page)

h. Endocrine

Had Have
○ ○ Thyroid issues
○ ○ Immune disorders
○ ○ Hypoglycemia
○ ○ Frequent infection
○ ○ Swollen glands
○ ○ Low energy
NONE ○ Initials ____

i. Genitourinary

Had Have
○ ○ Kidney stones
○ ○ Infertility
○ ○ Bedwetting
○ ○ Prostate issues
○ ○ Erectile dysfunction
○ ○ PMS symptoms
NONE ○ Initials ____

j. Constitutional

Had Have
○ ○ Fainting
○ ○ Low libido
○ ○ Poor appetite
○ ○ Fatigue
○ ○ Sudden weight gain/loss (circle one)
○ ○ Weakness
NONE ○ Initials ____

Patient name _____

Patient Number (office use only) _____

○ All other systems negative

Past Personal, Family and Social History

Please identify your past health history, including accidents, injuries, illnesses and treatments. Please complete each section fully.

PERSONAL

14. Illnesses

Check the illnesses you have **Had** in the past or **Have** now.

Had	Have		Had	Have	
○	○	AIDS	○	○	Tuberculosis
○	○	Alcoholism	○	○	Typhoid fever
○	○	Allergies	○	○	Ulcer
○	○	Arteriosclerosis	○	○	Other: _____
○	○	Cancer			
○	○	Chicken pox			
○	○	Diabetes			
○	○	Epilepsy			
○	○	Glaucoma			
○	○	Goiter			
○	○	Gout			
○	○	Heart disease			
○	○	Hepatitis			
○	○	HIV Positive			
○	○	Malaria			
○	○	Measles			
○	○	Multiple Sclerosis			
○	○	Mumps			
○	○	Polio Rheumatic fever			
○	○	Scarlet fever			
○	○	Sexually transmitted disease			
○	○	Stroke			

Please list any medical allergies here

_____

_____

_____

_____

_____

_____

15. Operations

Surgical interventions, which may or may not have included hospitalization.

- ○ Appendix removal
- ○ Bypass surgery
- ○ Cancer
- ○ Cosmetic surgery
- ○ Elective surgery: _____
- ○ Eye surgery
- ○ Hysterectomy
- ○ Pacemaker
- ○ Spine _____
- ○ Tonsillectomy
- ○ Vasectomy
- ○ Other: _____

16. Treatments

Check the ones you've received in the **Past** or are receiving **Currently**.

Past	Currently	
○	○	Acupuncture
○	○	Antibiotics
○	○	Birth control pills
○	○	Blood transfusions
○	○	Chemotherapy
○	○	Chiropractic care
○	○	Dialysis
○	○	Herbs
○	○	Homeopathy
○	○	Hormone replacement
○	○	Inhaler
○	○	Massage therapy
○	○	Physical therapy
○	○	Nutritional supplements:

List: _____

_____

_____

○ ○ **Medications (prescription & over-the-counter):**

_____

_____

_____

17. Injuries

Have you ever...

- ○ Had a fractured or broken bone
- ○ Had a spine or nerve disorder
- ○ Been knocked unconscious
- ○ Been injured in an accident
- ○ Used a crutch or other support
- ○ Used neck or back bracing
- ○ Received a tattoo
- ○ Had a body piercing

Consultation Notes

18. Family History

Some health issues are hereditary. Tell Paun Family Chiropractic and Wellness about the health of your immediate family members.

FAMILY

Relative	Age (If living)	State of health		Illnesses	Age at death	Cause of death	
		Good	Poor			Natural	Illness
Mother	_____	○	○	_____	_____	○	○
Father	_____	○	○	_____	_____	○	○
Sister 1	_____	○	○	_____	_____	○	○
Sister 2	_____	○	○	_____	_____	○	○
Brother 1	_____	○	○	_____	_____	○	○
Brother 2	_____	○	○	_____	_____	○	○

19. Are there any other hereditary health issues that you know about? _____

_____

20. Social History

Tell Paun Family Chiropractic and Wellness about your health habits and stress levels.

SOCIAL

Alcohol use	○ Daily ○ Weekly	How much? _____	
Coffee use	○ Daily ○ Weekly	How much? _____	
Tobacco use	○ Daily ○ Weekly	How much? _____	How long? _____
Exercising	○ Daily ○ Weekly	How much? _____	
Pain relievers	○ Daily ○ Weekly	How much? _____	
Soft drinks	○ Daily ○ Weekly	How much? _____	
Water intake	○ Daily ○ Weekly	How much? _____	

Hobbies: _____

Prayer or meditation?	○ Yes	○ No
Job pressure/stress?	○ Yes	○ No
Financial peace?	○ Yes	○ No
Vaccinated?	○ Yes	○ No
Mercury fillings?	○ Yes	○ No
Recreational drugs?	○ Yes	○ No

Doctor's Initials _____

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21. Activities of Daily Living
How does this condition currently interfere with your life and ability to function?

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Sitting	○	○	○	○
Rising out of chair	○	○	○	○
Standing	○	○	○	○
Walking	○	○	○	○
Lying down	○	○	○	○
Bending over	○	○	○	○
Climbing stairs	○	○	○	○
Using a computer	○	○	○	○
Getting in/out of car	○	○	○	○
Driving a car	○	○	○	○
Looking over shoulder	○	○	○	○
Caring for family	○	○	○	○

	No Effect	Mild Effect	Moderate Effect	Severe Effect
Grocery shopping	○	○	○	○
Household chores	○	○	○	○
Lifting objects	○	○	○	○
Reaching overhead	○	○	○	○
Showering or bathing	○	○	○	○
Dressing myself	○	○	○	○
Love life	○	○	○	○
Getting to sleep	○	○	○	○
Staying asleep	○	○	○	○
Concentrating	○	○	○	○
Exercising	○	○	○	○
Yard work	○	○	○	○

22. What is the major stressor in your life? _____

23. How much sleep do you average per night? _____ **Hours**

24. What is the type and approximate age of your mattress and pillow? _____

25. What is your preferred sleeping position? _____

26. Describe your typical eating habits: ○ Skip breakfast ○ Two meals a day ○ Three meals a day ○ Snacking between meals

Goals for your care
People see a chiropractor for a variety of reasons. Some go for relief of pain, some to correct the cause of pain, and others for correction of whatever is malfunctioning in their body. Your doctor will weigh your needs and desires when recommending your care program Please check the type of care desired so that we may be guided by your wishes whenever possible:

○ **I want the Doctor to select the type of care appropriate for my condition**

○ **Relief Care:** Symptomatic relief of pain or discomfort

○ **Corrective Care:** Correcting and relieving the cause of the problem as well as the symptom

○ **Comprehensive Care:** Bring whatever is malfunctioning in the body to the highest state of health possible with Chiropractic care.

Acknowledgements
To set clear expectations, improve communications and help you get the best results in the shortest amount of time, please read each statement and initial your agreement.

Initials ____ **I instruct the chiropractor to deliver the care that, in his or her professional judgment, can best help me in the restoration of my health. I also understand that the chiropractic care offered in this practice is based on the best available evidence and designed to reduce or correct vertebral subluxation. Chiropractic is a separate and distinct healing art from medicine and does not proclaim to cure any named disease or entity.**

Initials ____ **I may request a copy of the Privacy Policy and understand it describes how my personal health information is protected and released on my behalf for seeking reimbursement from any involved third parties.**

Initials ____ **I realize that an X-ray examination may be hazardous to an unborn child and I certify that to the best of my knowledge I am not pregnant. Date of last menstrual period (MM/DD/YYYY):** _____

Initials ____ **I grant permission to be called to confirm or reschedule an appointment and to be sent occasional cards, letters, emails or health information to me as an extension of my care in this office.**

Initials ____ **I acknowledge that any insurance I may have is an agreement between the carrier and me and that I am responsible for the payment of any covered or non-covered services I receive.**

Initials ____ **To the best of my ability, the information I have supplied is complete and truthful. I have not misrepresented the presence, severity or cause of my health concern.**

If the patient is a minor child, print child's full name: _____

Signature _____ Date (MM/DD/YYYY) _____

Patient name _____

Patient Number
(office use only) _____

Paun Family Chiropractic and Wellness, P.C.

Paun Family Chiropractic and Wellness, P.C.

Consent Form

Effective Date: December 2014

Please read each section and sign below, even if you are not receiving chiropractic care.

Health: a state of optimal physical, mental, and social well-being, not merely the absence of disease.

The most common therapeutic procedure performed by doctors of chiropractic is known as “spinal manipulation,” also called “chiropractic adjustment.” The purpose of manipulation is to restore joint mobility by manually applying a controlled force into joints that have become hypomobile – or restricted in their proper movement – as a result of a tissue injury. Tissue injury can be caused by a single traumatic event, such as improper lifting of a heavy object, or through repetitive stresses, such as sitting in an awkward position with poor spinal posture for an extended period of time. In either case, injured tissues undergo physical and chemical changes that can cause inflammation, pain, and diminished function for the sufferer. Manipulation, or adjustment of the affected joint (as well as the use of other modalities) and tissues restores mobility, thereby alleviated pain and muscle tightness, and allowing tissue to heal.

The material risks inherent in Chiropractic adjustment.
As with any health care procedure, there are certain complications which may arise during a chiropractic adjustment. Those complications include: fractures, dislocations, muscle strain, costovertebral strains and separations. Some types of manipulation of the neck have been associated with injuries to the arteries in the neck leading to or contributing to serious complications including stroke. Some patients will feel some stiffness and soreness following the first few days of treatment.

The probability of those risks occurring.
Fractures are rare occurrences and generally result from some underlying weakness of the bone which we check for during the timing of your history and during the examination. Stroke has been the subject of tremendous disagreement within and without the profession with one prominent authority saying that there is at most a one-in-a-million chance of such an outcome. Since even that risk should be avoided if possible, we employ tests in our examination which are designed to identify if you may be susceptible to that kind of injury.

I have read the above explanation of the chiropractic adjustment and related treatment. I have discussed it with my doctor and have had my questions answered to my satisfaction. By signing below I state that I have weighed the risks involved in undergoing treatment and have decided that it is in my best interest (or said minor's interest) to undergo the treatment recommended. Having been informed of the risks, I hereby authorize the Doctor to examine, perform diagnostic studies and treat my condition as he/she deems appropriate through the use of Chiropractic Health Care, and I give authority for these procedures to be performed. The Doctor will not be held responsible for any pre-existing medically diagnosed conditions nor for any medical diagnosis.

All questions regarding the doctor's objectives pertaining to my care in this office have been answered to my complete satisfaction. I therefore accept chiropractic care on this basis.

Patient/Guardian Signature: _____

(Date) _____

Paun Family Chiropractic and Wellness, P.C.

Assignment of Benefits – Financial Responsibility

Effective Date: December 2014

I hereby request that payment of authorized Medicare and all other third party insurance/payor benefits be made directly to Paun Family Chiropractic and Wellness, P.C. (PFCW) for any services furnished to me by that supplier. I hereby assign payment for services provided to me by PFCW are made directly to PFCW. I understand that I am financially responsible for any co- payments, deductibles and non-covered services. PFCW accepts assignment on all Medicare/pay or covered services/supplies unless otherwise notified. I further acknowledge that any benefits paid directly to the beneficiary for services provided by PFCW will be endorsed and delivered/mailed to PFCW within 10 days of receipt.

If, for any reason, you have an account in arrears with our office and we are not able to establish a repayment plan, your account will be sent to collections. This is used only as a last resort by this office. If this option must be used, a 20% fee will be added to your account to help with the fees incurred by this office. We will always work with you to get your account paid in full. If collections procedures fail to produce payment on your account, further action will be pursued in Small Claims Court, and any court and/or attorneys fees will be your responsibility. Any returned checks will be assessed a fee of $25.70 or 5% of the check amount, whichever is greater, in accordance with State of Indiana regulations. If payment arrangements are not established with our office within a reasonable amount of time (within 12 days of notice sent by our office), further action will be pursued through the Prosecutors' Office to recoup our costs.

I understand that my signature requests that payment by my insurance carrier be made directly to PFCW and that I am responsible for co-payments, deductibles and non-covered services.

I have read and fully understand the above statements.

Patient/Guardian Signature: _____

(Date) _____

Paun Family Chiropractic and Wellness, P.C.

Privacy Notice

Effective Date: December 2014

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GAIN ACCESS TO THIS INFORMATION. PLEASE REVIEW THIS NOTICE CAREFULLY.

This Notice of Privacy (NOP) describes how we may use and disclose your Protected Health Information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law. It also describes your rights to access and control your PHI. "Protected Health Information" is information about you, including demographic information, that may identify you and that relates to your past, present or future physical or mental health condition and related health care services.

USES AND DISCLOSURES OF PROTECTED HEALTH INFORMATION

Treatment: We may use and disclose your personal information to provide you with treatment or services. For example, we may use your health information to prescribe a course of treatment or make a referral. We will record your current healthcare information in a record so, in the future, we can see your medical history to help in diagnosing and treatment, or to determine how well you are responding to treatment. We may provide your health information to other health providers, such as referring or specialist physicians, to assist in your treatment. Should you ever be hospitalized, we may provide the hospital or its staff with the health information it requires to provide you with effective treatment.

Payment: We may use and disclose your health information so that we may bill and collect payment for the services that we provided to you. For example, we may contact your health insurer to verify your eligibility for benefits, and may need to disclose to it some details of your medical condition or expected course of treatment. We may use or disclose your information so that a bill may be sent to you, your health insurer, or a family member. The information on or accompanying the bill may include information that identifies you and your diagnosis, as well as services rendered, any procedures performed, and supplies used. Also, we may provide health information to another health care provider, such as an ambulance company that transported you to our office, to assist in their billing and collection efforts.

Health Care Operations: We may use and disclose your health information to assist in the operation of our practice. For example, members of our staff may use information in your health record to assess the care and outcomes in your case and others like it as part of a continuous effort to improve the quality and effectiveness of the healthcare and services we provide. We may use and disclose your health information to conduct cost-management and business planning activities for our practice. We may also provide such information to other health care entities for their health care operations. For example, we may provide information to your health insurer for its quality review purposes.

Other Permitted and Required Uses and Disclosure will be made **only** with your consent, authorization or opportunity to object unless required by law. You may revoke the authorization, at any time, in writing, except to the extent that your physician or the physician's practice has taken an action in reliance on the use or disclosure indicated in the authorization.

YOUR HEALTH INFORMATION RIGHTS

The following are statements of your rights with respect to your protected health information:

Right to Obtain a Paper Copy of This Notice: You have the right to a paper copy of this Notice of Privacy Practices at any time. Even if you have agreed to receive this notice electronically,

you are still entitled to a paper copy.

Right to Inspect and Copy: You have the right to inspect and copy medical information that may be used to make decisions about your care. Usually, this includes medical and billing records, but does not include psychotherapy notes. You have a right to information that is stored electronically that is not in EHR software, including information stored in MS Word, Excel, PDF, plain text and other electronic formats. To inspect and copy medical information, you must submit a written request to our privacy officer. We will supply you with a form for such a request. If you request a copy of your **medical information, we may** charge a reasonable fee for the costs of labor, postage, and supplies associated with your request. We may not charge you a fee if you require your medical information for a claim for benefits under the Social Security Act or any other state or federal needs-based benefit program. If your medical information is maintained in an electronic health record, you also have the right to request that an electronic copy of your record be sent to you or to another individual or entity. We may charge you a reasonable cost based fee limited to the labor costs associated with transmitting the electronic health record. You have a right to have this information with-in 30 days of receipt of your request.

Right to Amend: If you feel that medical information we have about you is incorrect or incomplete, you may ask us to amend the information. You have the right to request an amendment for as long as we retain the information. To request an amendment, your request must be made in writing and submitted to our privacy officer. In addition, you must provide a reason that supports your request. We may deny your request for an amendment if it is not in writing or does not include a reason to support the request. In addition, we may deny your request if you ask us to amend information that:

- was not created by us, unless the person or entity that created the information is no longer available to make the amendment;
- is not part of the medical information kept by or for [name of provider];
- is not part of the information which you would be permitted to inspect and copy; or
- is accurate and complete.

If we deny your request for amendment, you may submit a statement of disagreement. We may reasonably limit the length of this statement. Your letter of disagreement will be included in your medical record, but we may also include a rebuttal statement.

Right to an Accounting of Disclosures: You have the right to request an accounting of disclosures of your health information made by us. In your accounting, we are not required to list certain disclosures, including:

- disclosures made for treatment, payment, and health care operations purposes or disclosures made incidental to treatment, payment, and health care operations, however, if the disclosures were made through an electronic health record, you have the right to request an accounting for such disclosures that were made during the previous 3 years;
- disclosures made pursuant to your authorization;
- disclosures made to create a limited data set;
- disclosures made directly to you.

To request an accounting of disclosures, you must submit your request in writing to our privacy officer. Your request must state a time period which may not be longer than six years and may not include dates before April 14, 2003. Your request should indicate in what form you would like the accounting of disclosures (for example, on paper or electronically by email). The first accounting of disclosures you request within any 12 month period will be free. For additional requests within the same period, we may charge you for the reasonable costs of providing the accounting of disclosures. We will notify you of the costs involved and you may choose to withdraw or modify your request at that time, before any costs are incurred. Under limited circumstances mandated by federal and state law, we may temporarily deny your request for an accounting of disclosures.

Right to Request Restrictions: You have the right to request a restriction or limitation on the medical information we use or disclose about you for treatment, payment, or health care operations. You also have the right to request a limit on the medical information we communicate about you to someone who is involved in your care or the payment for your care. You have a right to restrict certain disclosures of Protected Health Information to a health plan where you have paid out of pocket in full for the healthcare item or service. As noted above, we are not required to agree to your request. If we do agree, we will comply with your request unless the restricted information is needed to provide you with emergency treatment. To request restrictions, you must make your request in writing to our privacy officer. In your request, you must tell us what information you want to limit, whether you want to limit our use, disclosure, or both and to whom you want the limits to apply.

Right to Request Confidential Communications: You have the right to request that we communicate with you about medical matters in a certain way or at a certain location. For example, you can ask that we only contact you at work or by e-mail. To request confidential communications, you must make your request in writing to our privacy officer. We will accommodate all reasonable requests.

Right to Receive Notice of a Breach: We are required to notify you by first class mail or by email (if you have indicated a preference to receive information by e-mail), of any breaches of Unsecured Protected Health Information as soon as possible, but in any event, no later than 60 days following the discovery of the breach. "Unsecured Protected Health Information" is information that is not secured through the use of a technology or methodology identified by the Secretary of the U.S. Department of Health and Human Services to render the Protected Health Information unusable, unreadable, and undecipherable to unauthorized users.

COMPLAINTS

If you believe your privacy rights have been violated, you may file a complaint with us or with the Secretary of the U.S. Department of Health and Human Services. **We will not retaliate against you for filing a complaint.** To file a complaint with us, contact our privacy officer at the address listed above. All complaints must be submitted in writing and should be submitted within 180 days of when you knew or should have known that the alleged violation occurred.

APPOINTMENT REMINDERS

We may use and disclose Information in your medical record to contact you as a reminder that you have an appointment at [name of provider]. We usually will call you at home the day before your appointment and leave a message for you on your answering machine or with an individual who responds to our telephone call. However, you may request that we provide such reminders only in a certain way or only at a certain place. We will endeavor to accommodate all reasonable requests.

We are required by law to maintain the privacy of, and provide individuals with, this notice of our legal duties and privacy practices with respect to protect health information. We are also to abide by the terms of the notice currently in effect. If you have any questions in reference to this form, please ask to speak with our HIPAA Compliance Officer in person or by phone at our main phone number.

By signing this Agreement, you are only acknowledging that you have received or been given the opportunity to receive a copy of our Notice of Privacy Practices.

Signature: _____ Date_____

Print Name: _____

Paun Family Chiropractic and Wellness, P.C.

Cancellation Policy

Effective Date: December 2014

At Paun Family Chiropractic and Wellness, P.C., we have extended hours to accommodate our patients and their increased demands of life.

In return, we request that we be notified twenty four (24) hours before any cancellation. This allows us the opportunity to properly schedule other patients in need of our services and to efficiently work around our own schedules.

A $25.00 fee will be automatically charged to your account (per occurrence) if this policy is abused. Please note that we will take unforeseen circumstances into consideration and that this is mostly in effect for people who have a tendency to disregard our schedule.

If you have any questions, comments or concerns please feel comfortable to speak with the Drs. Paun to avoid any miscommunication.

We appreciate your cooperation with this matter.

I understand the cancellation policy of Paun Family Chiropractic and Wellness, P.C. and the fees associated with violation of this policy.

Signature:_____

Date: _____

Paun Family Chiropractic and Wellness, P.C.

Financial Policy

Effective Date: December 2014

It is our office policy that payment for services rendered is ultimately the responsibility of the patient, whether or not you have third party assistance with your financial obligation. We are happy to extend a payment plan to you so that you can follow through with all the care you may require.

All patient fees are expected at the time of service or according to a preset payment plan or program. Personal balances may not exceed $300 unless on a pre-arranged payment plan. Payment plans are available to ensure you are able to receive all the care you may require.

For your convenience, this office accepts cash, checks, and the following credit cards: Visa, MasterCard, Discover, and Care Credit.

This office participates in a discount medical plan organization (DMPO) and offers discounted fees to uninsured, underinsured, or partially insured patients who are members. We will assist you in learning more about this should you wish to access these discounted fees.

This office does not turn away any patient due to their ability to pay. If you feel you might qualify for our financial hardship policy, notify the office immediately so we can begin your qualification process.

Should payment be refused by your bank for any check written, this office will charge a fee of $25.70 or 5% of check amount (whichever is greater) to offset the charges we will incur as a result of the returned check.

Any balance left unpaid after a period of 120 days will be assessed an interest charge of 1.5 percent per month (18% APR).

As a courtesy to our patients, this office will bill third party payers, accept assignment, and wait to be paid for some portion of our patients' financial responsibility.

The privilege of insurance assignment begins when our office receives and verifies your insurance information. Until that time, you are considered a “cash” patient and payment is expected at the time of service. As a courtesy to you, our office will pre-qualify your insurance coverage, in an effort to help you determine what coverage is available to you under your policy. We will help you make the best estimate of your coverage for the recommend services. This service is a courtesy to you and is not a guarantee of coverage.

No one can predict what an insurance company will pay for the usual and customary charges for services rendered. If we participate on your plan, you will not encounter balance billing above the stated fee schedule. If we do not participate, we will work with you to determine the amount of coverage and help estimate your responsibility.

If your insurance has not paid on an assigned bill within 90 days, you will be notified. Since we do not own your policy, we ask that you stay in communication with our office and take action with your insurance company at that time. If it remains unpaid within 120 days the balance becomes due and payable immediately and your assignment is revoked.

All patients whose treatment visitation schedule is once per month or longer will no longer be eligible for insurance assignment as this level of care is rarely covered by insurance. Our office offers numerous payment options to allow you to continue maintenance, wellness, or supportive care.

Should you discontinue care for any reason, other than discharge by the doctor, any and all balances will become due and payable at that time. If you are on a predetermined payment plan, that plan will continue to be in effect until your balance is zero.

Signed: _____ Date: _____

Witness: _____ Date: _____

Paun Family Chiropractic and Wellness, P.C.

Join Our Email Newsletter!

Would you like to join our Paun Wellness email newsletter to receive wellness tips, nutrition advice, office updates, and exclusive offers? (We promise never to spam or sell your email.)

☐**Yes** ☐**NO**

If yes, please list your email below:

_____

Paun Family Chiropractic and Wellness, P.C.

HIPAA Notice – Patient Copy

I hereby state that by signing this Consent, I acknowledge and agree as follows:

1. The Privacy Notice of Paun Family Chiropractic and Wellness, P.C. (PFCW) will be provided to me upon my request. The Privacy Notice includes a complete description of the uses and/or disclosures of my protected health information (PHI) necessary for PFCW to provide treatment to me, and also necessary for PFCW to obtain payment for that treatment and to carry out its health care operations. PFCW has further explained my right to obtain a copy of the Privacy Notice prior to signing this Consent, and has encouraged me to read the Privacy Notice prior to my signing this Consent.

2. PFCW reserves the right to change its privacy practices that are described in its Privacy Notice, in accordance with applicable laws.

3. I understand that, and consent to, the following appointment reminders or communications that will be used by PFCW:
   a.) a postcard mailed to me at the address provided by me; and
   b.) Telephoning my home or cellular phone and leaving a message on my answering machine or with the individual answering the phone.

4. PFCW may use and/or disclose my PHI to the third party (which includes information about my health or condition and the treatment provided to me) in order to treat me and obtain payment for that treatment, and as necessary for PFCW to conduct its specific health care operations.

5. I understand that I have a right to request that PFCW restrict how my PHI is used and/or disclosed to carry out treatment, payment and/or health care operations. However, PFCW is not required to agree to any restrictions that I have requested. If PFCW agrees to a requested restriction, then the restriction is binding on PFCW.

6. I understand that this Consent is valid for seven years. I further understand that I have the right to revoke this Consent, in writing, at any time for all future transactions, with the understanding that any such revocations shall not apply to the extent that PFCW has already taken action in reliance on this consent.

7. I understand that if I revoke this Consent at any time, PFCW has the right to refuse to treat me.

8. I understand that if I do not sign this Consent evidencing my consent to the uses and disclosures described to me above and contained in the Privacy Notice, then PFCW will not treat me.

AUTHORIZATION FOR RELEASE OF RECORDS

Paun Family Chiropractic and Wellness, P.C. is authorized to disclose to my attorney, or his / her agent, as well as to any insurance carrier who may be liable for payment of bills and charges for services rendered to me, any information which may be acquired by examination, or other means, of my physical and mental condition; and I hereby release PFCW of any consequences thereof.

Due to Federal and State Laws we are required to safeguard your medical information including any diagnostic films (X-rays, MRI, etc). We will send any films to the physician you requested via certified mail and you will be responsible for the postage at the time of the request.